STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185295	A. BUILDING _____ B. WING _____	C 03/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOVER MANOR	112 DOVER DRIVE GEORGETOWN, KY 40324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating ARO #KY00015665, KY00015890, KY00015996, KY00015280, KY00015525, and KY00015683 was initiated on 03/15/11 and concluded on 03/18/11. ARO #KY00015665 and KY00015890 were substantiated with deficiencies cited at 483.15 Resident Rights. ARO #KY00015996 was substantiated with no deficiencies cited. ARO #KY00015280, KY00015525, and KY00015683 were unsubstantiated with no deficiencies cited.	F 000	F 223 SRNA #14 was terminated on 10/28/10, immediately after substantiation of abuse allegation. SRNA # 13 was terminated on 12/23/10, Immediately after substantiation of abuse Allegation. All alert residents in the facility were interviewed on 3/30, and 3/31/11, to	
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to protect five (5) of twelve (12) sampled residents (Residents #1, #2, #7, #8, and #9) from verbal abuse. Interview and record review revealed, on 10/28/10 State Registered Nurse Aide (SRNA) #14 was verbally abusive to three (3) residents (Residents #7, #8, and #9), between 8:15 AM and 10:00 AM and the facility failed to protect residents from abuse. Further, interview and record review revealed SRNA#1 and #2 witnessed SRNA#13 verbally abuse Resident #1 on 12/22/10 at 11:00 AM.	F 223	determine if any resident felt they had either been a victim of abuse, or had witnessed an occurrence of abuse. None was identified. All employees in the facility, and all contractors employees regularly working in the facility have been in-serviced on 3/22, 3/23, 3/24, 3/25, 3/26, 3/28, 3/30, and 3/31/2011, regarding the necessity of reporting any allegation of abuse immediately to the Administrator, DON, or Director of Social Services, who will make a report immediately twenty-four hours per day. it was also stressed that employees involved in an allegation of abuse must be relieved of duty immediately upon receipt of any allegation of abuse. All employees have been instructed regarding their responsibility to report any allegation of abuse, which is a regular component of our Abuse In-Service for new employee orientation, and annual updates.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Tuttle | TITLE: Administrator | (X6) DATE: 4/1/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 However, they failed to report the incident to the Assistant Director of Nursing (ADON) until 3:00 PM. SRNA #13 was allowed to work on 12/23/10. Around 8:15 AM, SRNA #5 witnessed SRNA #13 verbally abuse Resident #2. The facility failed to protect residents from abuse by failing to remove SRNA #13 from residents' care until 11:00 AM. The findings include: 1. Review of the facility's Abuse Prevention Policy and Procedure revealed verbal abuse was defined as the use of oral language that willfully includes disparaging and derogatory terms to residents or within their hearing distance. The policy further indicated that any incident of abuse should be reported to administration immediately. Review of the facility's investigation revealed SRNA #2 and SRNA #4 heard SRNA #14 yelling at Resident #8 on 10/28/10, while giving the resident a shower around 8:15 AM. Interview with SRNA #2 on 03/17/11 at 9:45 AM revealed she heard SRNA #14 say "Shit, (Resident #8), the water is not cold". SRNA #2 said she reported the incident to her charge nurse, but did not remember who the charge nurse was that day. Interview with SRNA #3 on 03/17/11 at 10:00 AM revealed she heard SRNA #14 yelling and cursing at Resident #7 on 10/28/10 around 10:00 AM while giving Resident #7 a shower. Interview revealed SRNA #14 was yelling loud and used the word "shit" towards the resident. SRNA #3 stated SRNA #4 heard it as well and she thought SRNA #4 reported the incident to the ADON. Interview with SRNA #4 on 03/17/11 at 11:20 AM revealed she heard SRNA #14 yelling at Resident	F 223	F 223 (Con't.) The potential for failure to report an allegation of abuse will be controlled and monitored through daily checks with department heads and charge nurses each morning for the next 60 days to determine if anything occurred that might constitute abuse that was not reported. Reports will be documented by Director of Social Services on a daily basis, and reported to CQI Committee weekly. Any failure to report will be immediately reported to the Administrator and DON. **F 223 Completed 4/1/2011**	

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F 223	Continued From page 2 #7 in the shower on 10/28/10 around 10:00 AM. Interview further revealed she witnessed SRNA #14 telling Resident #9 that she would shove the wheel chair into the back of the resident's legs if he/she didn't sit down on 10/28/10 around 9:00 AM. She further stated that she did not tell the ADON about either incident until around 11:00 AM on 10/28/10. Interview with the ADON on 03/18/11 at 3:15 PM revealed all staff were trained upon hire to report any incident of verbal abuse to administration immediately. She stated she was not aware of any of the verbal abuse incidents involving Residents #7, #8, or #9 until around 11:00 AM on 10/28/10 at which time she suspended SRNA #14 and conducted an investigation. 2. Interview with SRNA #1 on 03/17/11 at 9:00 AM revealed on 12/22/10, around 11:00 AM, she witnessed SRNA #13 swat at Resident #1's hand and say "quit digging at your shit, you nasty Bitch". SRNA #1 said the incident was also witnessed by SRNA #2. Interview revealed she thought she reported this to the charge nurse, not sure which one, immediately, but knew she reported to the ADON at 3:00 PM when she was leaving for the day. Interview with SRNA #2 revealed she witnessed SRNA #13 swat at Resident #1's hand and say "quit digging at your shit, you nasty Bitch". SRNA #2 stated she thought SRNA #1 had reported the incident. She further stated both she and SRNA #1 talked to the ADON about the incident as they were leaving for the day around 3:00 PM. Interview with SRNA #5 on 03/17/11 at 9:50 AM revealed she was working with SRNA #13 on	F 223		

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F 223	Continued From page 3 12/23/10. She stated at 8:15 AM Resident #2 went to hit at SRNA #13 when she grabbed at Resident #2's hand and said "quit you old Bastard". She stated she did not report the incident until 11:00 AM, even though she had been trained to report incidents of verbal abuse immediately. Interview with the ADON on 03/18/11 at 3:15 PM revealed she asked the Aides for written statements at the time. She further stated she failed to suspend SRNA #13 during the investigation as per facility policy. Further interview revealed SRNA #13 was terminated at 11:00 AM, but should not have been allowed to work on 12/23/10 due to the allegations from the previous day. Interview with the Director of Nursing (DON) on 03/18/11 at 3:20 PM revealed the facility realized there was a problem with the Aides reporting incidents immediately and re-educated all the staff on the facility's policy. She further stated the facility failed to follow it's policy and should have suspended SRNA #13 on 12/22/10.	F 223		